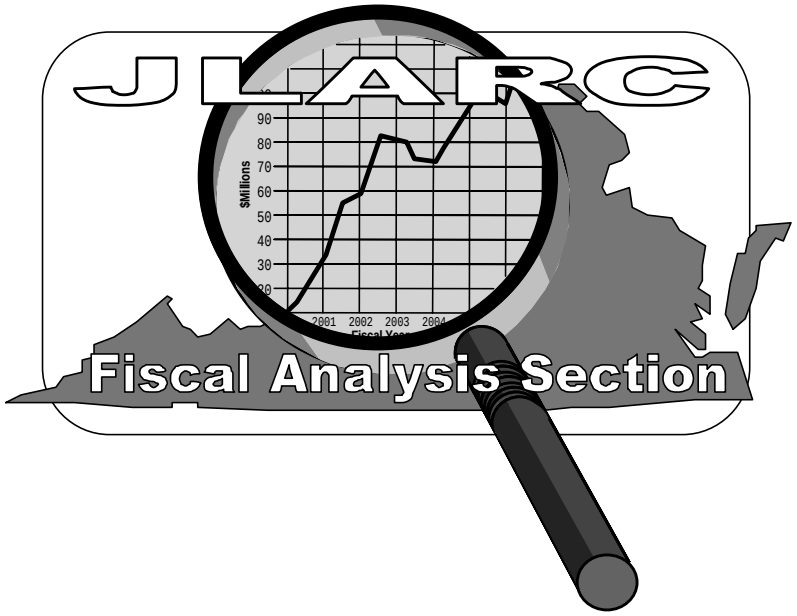
Joint Legislative Audit and Review Commission
of the Virginia General Assembly



Special Report:

State Spending on Medical Supplies and Pharmaceuticals

Staff Briefing
Patricia Bishop, Project Leader
December 16, 2002

Introduction

Staff for this study:

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Study Mandate

- **In January 2002, JLARC staff completed a *Review of State Spending.* This report assessed spending across all State agencies.**

- **Following the June 2002 update to the JLARC *Review of State Spending,* JLARC directed staff to undertake a follow-up review focused specifically on the methods and procedures used to procure pharmaceuticals and medical supplies.**

Presentation Outline

- ☑ **Overview of Medical Supply and Pharmaceutical Procurement**
- ☐ **Assessment of Opportunities for Savings in the Areas Reviewed**
  - **Implementation of a preferred drug list (PDL) at the Department of Medical Assistance Services (DMAS)**
  - **Change in pharmaceutical reimbursement rates for dispensing and ingredient fees at DMAS**
  - **Expansion of the federal 340B drug-pricing program**
  - **Inclusion of a tiered co-payment structure for prescription drugs for for State's self-insured health care plans**

FY 2002 Total Pharmaceutical and Medical Supply Spending Across Selected Agencies

Agency	Medical Supplies		Pharmaceuticals		
DHRM	$0		$124.9		
DJJ	0.3		0.8		
DMAS	0.1		443.4		
DMHMRSAS	3.4		35.5		
DOC	3.6		13.1		
UVA	61.9		40.4		
VDH	8.8		23.1		
Total	78.1		681.2		
Total State Spending	$129.3	+	$681.9	=	$811.2

Medical Supply Procurement

- **The Commonwealth spent $129 million in FY 2002 for medical supplies.**
- **The seven State agencies highlighted in this report constituted more than 60 percent of this statewide total.**
- **Expenditures for the UVA Health System were almost 50 percent of the statewide total or the largest single percentage of medical supply purchases.**
- **The majority of medical supply purchasing is done through State contracts and the group purchasing organization used by UVA.**

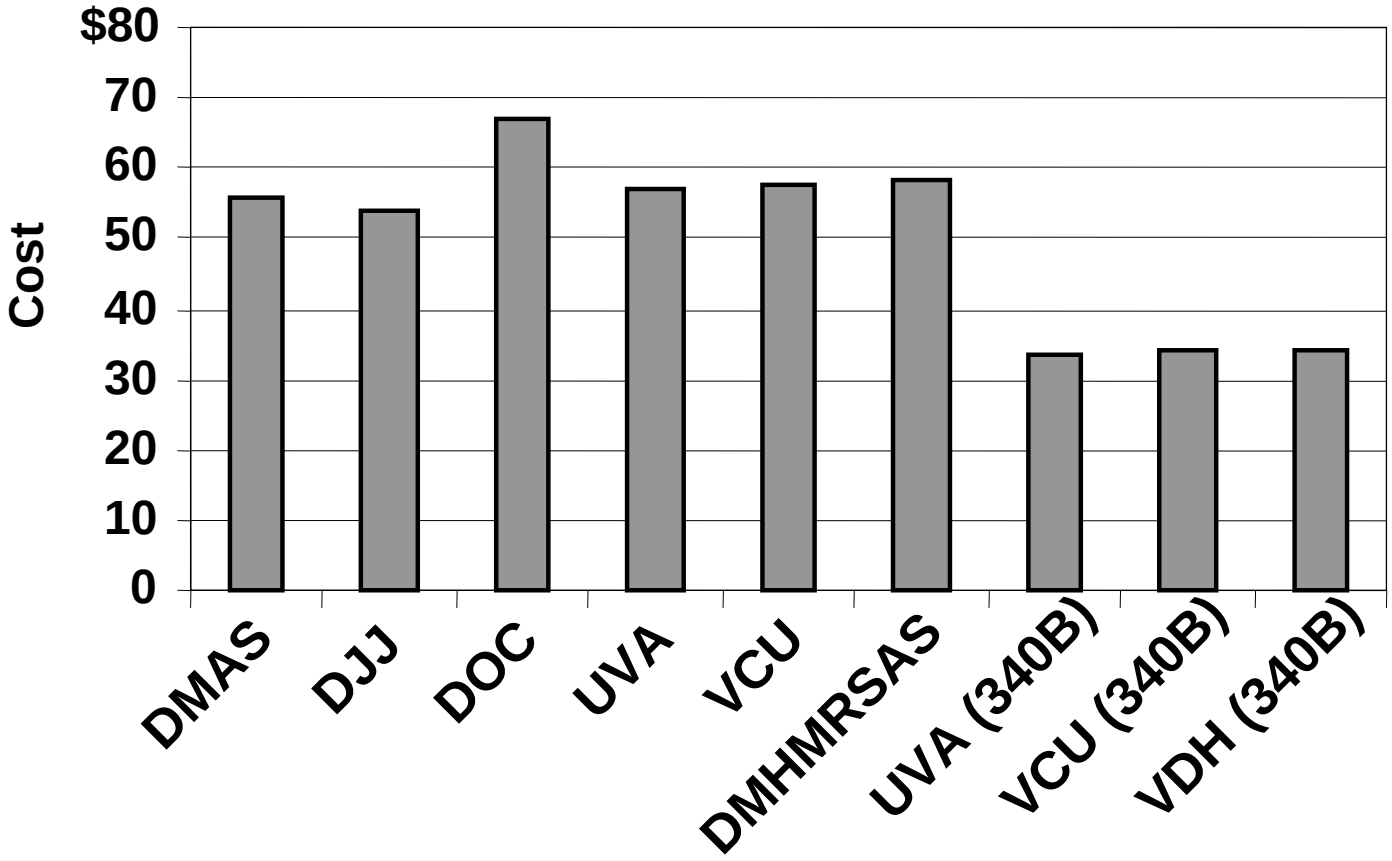
Group Purchasing Organizations (GPO)

- **GPOs are generally owned by their members (hospitals or other health care providers) and use volume purchasing as leverage in negotiating with vendors.**
  - **GPOs offer indirect savings in the form of reduced contracting costs and increased process efficiencies**
  - **The majority of pharmaceutical purchases at UVA and VCU are done through Novation, one of the nation's largest GPOs**
- **DMHMRSAS and VDH utilize a GPO called the Minnesota Multi-state Contracting Alliance for Pharmacy (MMCAP).**
- **As DOC and DJJ do not operate in-house pharmacies, these agencies contract with full-service mail order pharmacies for care provided on-site. For off-site prescription drugs and claims processing services, DOC and DJJ contract with a third-party provider.**

Prescription Drug Purchases

- State entities obtain pharmaceuticals through a variety of different methods, including group purchasing organizations, State contracts, and contracts with full-service mail-order pharmacies.
- DMAS and DHRM account for approximately 75 percent of all State pharmaceutical expenditures.
- DMAS and DHRM do not procure pharmaceuticals directly; rather they reimburse pharmacies and other entities for claims made on behalf of their members or clients.

Comparison of 2002 Drug Prices Paid by Selected Agencies (Flovent 110 mcg)



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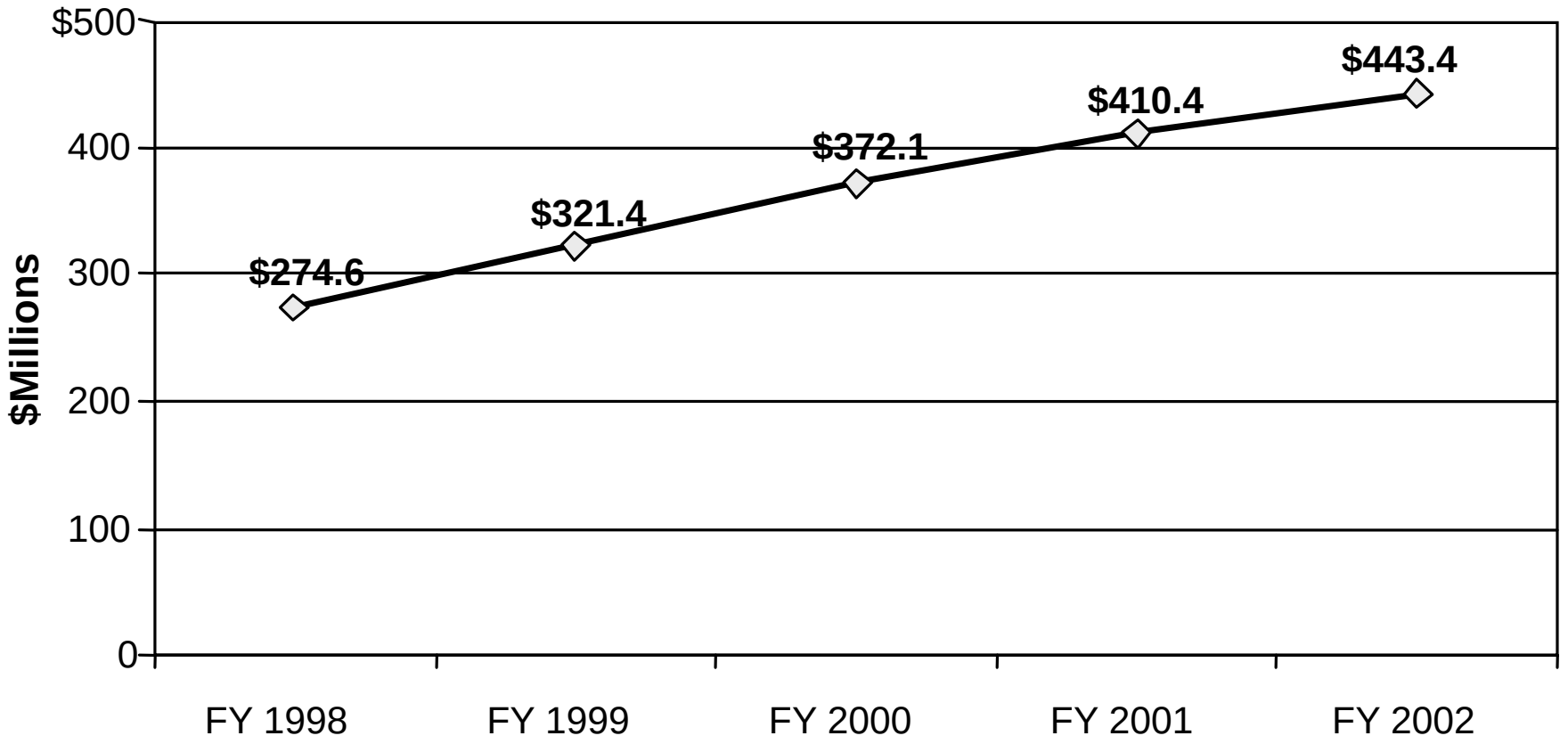
Potential Savings

Initiative	Range of Savings (Annually, $Millions)
Preferred Drug List	$17.8 – $22.0
AWP Change	$1.6 – $10.4
Dispensing Fee Decrease	$1.1 – $7.5
DOC Expansion of 340B	$1.6 – $3.0
340B Hospital Expansion	$0.2 – $1.7
Total Potential General FundSavings	$22.3 – $44.6
DHRM Tiered Co-pay	$4.2 – $5.7
Total Potential Non-General Fund Savings	$4.2 – $5.7
Grand Total	$26.5 – $50.3

Medicaid Fee-for-Service Pharmaceutical Expenditures (General and Non-General Funds)
FY 1998 to FY 2002



Preferred Drug List

- Utilized by other state employee health plans, private hospitals, health maintenance organizations, and pharmacy benefit managers.
- Preferred Drug Lists (PDLs) are an increasingly popular method of containing pharmaceutical costs within state Medicaid programs. Several states, including Michigan, Florida, Georgia and California, currently utilize PDLs.
- PDLs are developed by Pharmaceutical and Therapeutics Committees, which
  - Utilize prior authorization plans
  - Divide allowable prescription drugs in to two categories:
    - Those that require prior authorization
    - Those that do not

Preferred Drug List

- According to other states and industry experts, PDLs are estimated to save approximately eight to ten percent of Medicaid prescription drug costs.
- Savings are achieved by
  - Encouraging the use of generic drugs
  - Promoting the use of low cost therapies prior to utilization of high cost alternatives
  - Providing the states with the leverage necessary to negotiate supplemental rebates.
- Michigan officials estimate savings of approximately $900,000 per week, or roughly nine percent of prescription drug costs.
- A PDL could generate approximately $17.8 million to $22 million in general fund savings.

Preferred Drug List

- **While the potential savings are substantial, there are several obstacles to implementing a PDL in Virginia that must be considered.**
  - **Pending PhRMA litigation**
  - **Resource intensive**
  - **Requires an effective prior authorization program.**

Recommendation

- ***Recommendation (1).*** **Pending the resolution of current litigation from other states, the General Assembly may wish to amend Section 32.1-331.13-14 of the Code of Virginia to facilitate the creation and operation of a Preferred Drug List (PDL) within the Virginia Medicaid program. To facilitate this process, the General Assembly may wish to authorize DMAS to appoint a Pharmacy and Therapeutics committee qualified to evaluate drugs for inclusion. The PDL should be based on safety and efficacy, and then price, rather than solely on price. In order to successfully implement a PDL, the General Assembly may wish to streamline the prior authorization statute, including the removal of the dual public comment period**

Medicaid Drug Reimbursement Rate

- **DMAS's current reimbursement rate for pharmaceutical drugs, as set by the General Assembly, is Average Wholesale Price (AWP) minus 10.25 percent.**
- **National average is AWP less 12 percent. 10 states have lower discount rates, paying more than Virginia.**
- **JLARC staff estimate that a change from AWP less 10.25 percent to AWP less 12 percent would result in approximately $3.8 million in general fund savings.**

Additional Methods for Reimbursement

- **Most states reimburse brand-name drugs based on average wholesale price (AWP).**

- **Six states currently use wholesale acquisition cost (WAC) plus a percentage, in the place of AWP less a percentage, to reimburse pharmacies for prescription drugs.**
  - **Unlike AWP, which is based on the suggested retail price of the drug, WAC is determined by the actual price paid by the pharmacy to the wholesaler.**
  - **Maryland reported achieving substantial savings on generic drugs by using WAC in the place of AWP.**

Recommendation

- ***Recommendation (2).*** **The General Assembly may wish to direct the Department of Medical Assistance Services (DMAS) to conduct an analysis to determine the average wholesale price (AWP) and the wholesale acquisition cost (WAC). Based upon the results of the analysis, DMAS should develop and implement a plan to: (1) increase the AWP discount rate to more accurately reflect national averages and (2) determine whether to incorporate or replace the AWP reimbursement rate with the use of the WAC plus a percentage**

Additional Methods for Reimbursement

- **DMAS currently defines Usual and Customary (U&C) as the price paid by a cash-paying customer.**
  - **Cash paying customers typically pay the highest price for retail drugs.**
- **Several states, including Georgia, have defined U&C as the lowest of best price a pharmacist charges to any other payer.**
  - **Georgia reported that this best price provision has allowed the state to pay reimbursements as low as AWP less 45 percent for generic drugs, in contrast to their rate of AWP less 10 percent.**

Recommendation

- ***Recommendation (3).*** **The General Assembly may wish to direct the Department of Medical Assistance Services to promulgate regulations to change the definition for its Usual and Customary reimbursement rate to the lowest price a pharmacist charges to any other payer.**

Medicaid Pharmacy Dispensing Fee

- As mandated by VAC 30-120-80, DMAS currently pays pharmacies a $4.25 dispensing fee per prescription.
- Other State agencies, DOC and DHRM for example, currently pay significantly lower dispensing fees than DMAS.
- The Heinz Family Foundation reported that commercial managed care dispensing fees range from $1.75 to $2.50.
- JLARC staff estimate that decreasing the dispensing fee at DMAS could save up to $7.5 million in general funds
- JLARC staff estimate that even a modest reduction in the dispensing fee from $4.25 to $4.00 would result in $1.1 million general fund savings.

Recommendation

- ***Recommendation (4).*** **The General Assembly may wish to decrease the pharmacy dispensing fee for Medicaid fee-for-service prescription drugs to be more consistent with Virginia's private payer dispensing fees.**

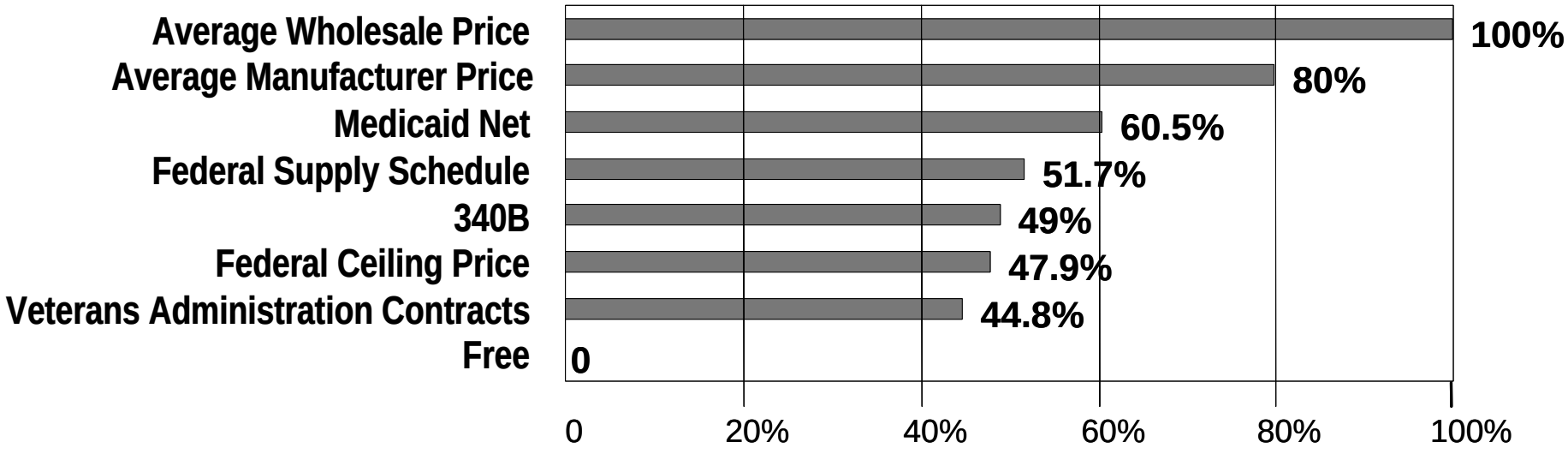
Federal 340B Drug-Pricing Program

- **Established through the Veterans Health Care Act of 1992, the federal 340B drug-pricing program offers federal drug purchasers outpatient pharmaceuticals at discounted rates.**

- **The program is limited to disproportionate share hospitals owned or under contract with a state government, federally qualified health centers, and various public health entities.**

Federal 340B Drug-Pricing Program

Estimated Relative Price Compared to AWP for Prescription Drugs at Manufacturer Level



Options for Savings Using the Federal 340B Drug-Pricing Program

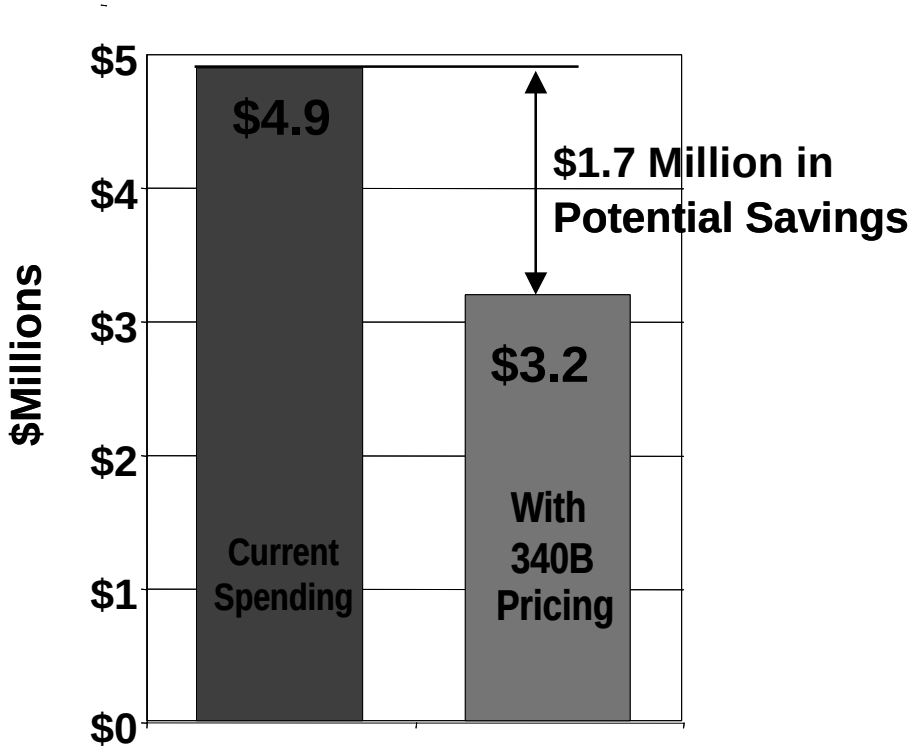
- **Developing cooperative relationships with Virginia's disproportionate share hospitals would enable State agencies to utilize 340B prices.**

- **Increasing participation by Virginia's disproportionate share hospitals would yield additional savings to the State**
  - **The Public Hospital Pharmacy Coalition estimates savings through reduced billing to Medicaid of $300,000 or $150,000 per year in general funds**
  - **Participation by all Virginia eligible entities would result in additional general fund savings of approximately $1.7 million.**

- **Using 340B for targeted populations**
  - **Utah Medicaid has developed a case management program through which its hemophiliacs receive their Factor drugs at 340B prices.**
  - **340B drug-pricing could be used for HIV and antiretroviral drugs at DOC**

Federal 340B Drug-Pricing Program

Potential Savings at DOC (FY 2002) through Applying 340B Pricing to HIV/Anti-Retroviral Medicines



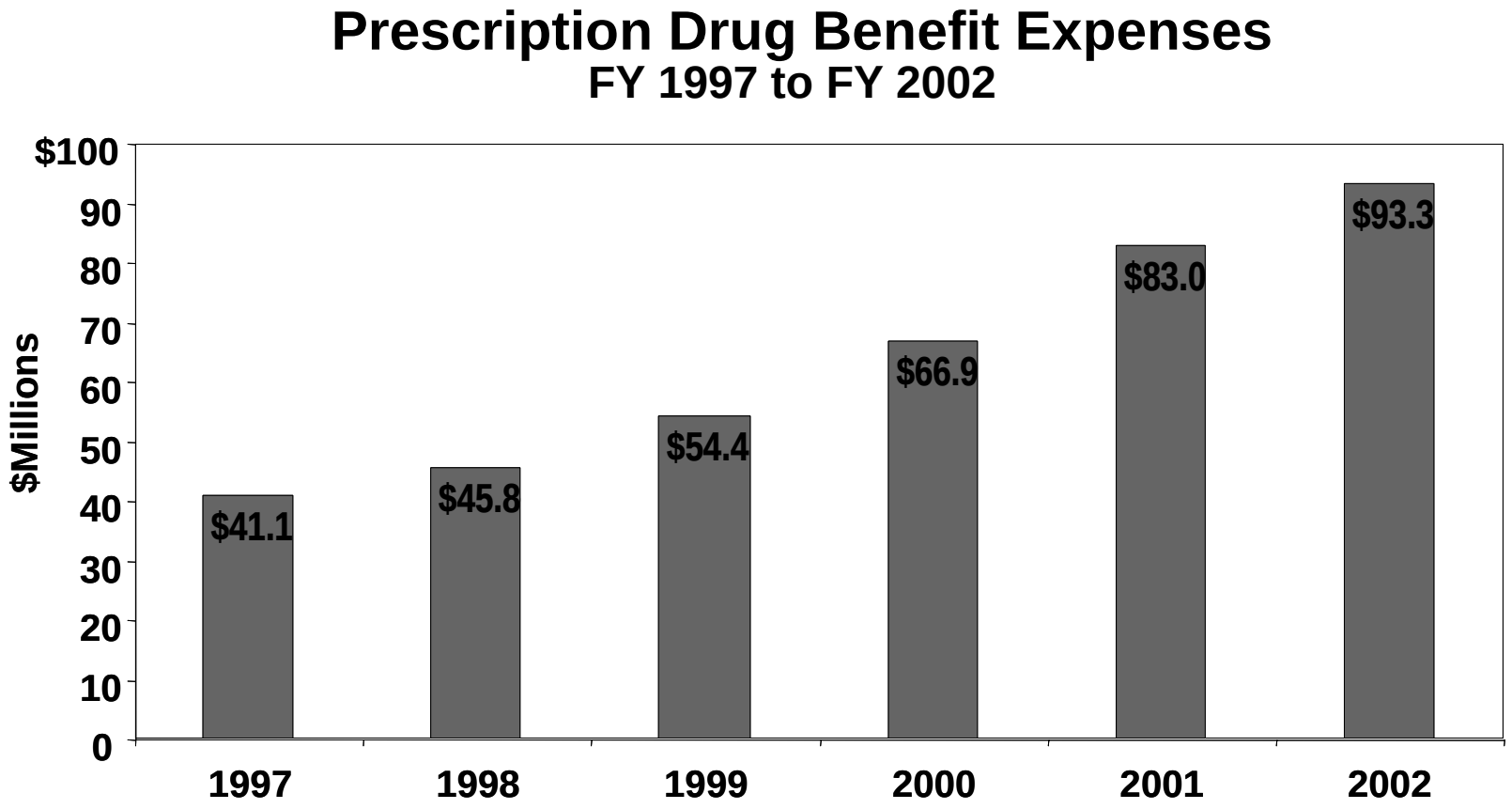
Recommendation

- ***Recommendation (5).*** **The General Assembly may wish to direct DOC, DJJ, DMHMRSAS, UVA and VCU to examine the potential for cooperative arrangements which would allow entire agencies or targeted populations within the agencies to procure pharmaceuticals through 340B drug-pricing program and report the results to the General Assembly prior to the 2004 session.**

Recommendation

- ***Recommendation (6).*** **The General Assembly may wish to direct the Secretary of Health and Human Resources to establish formal relationships with interested not-for-profit hospitals to enable them to become 340B eligible. In addition, the Secretary should report back to the General Assembly prior to the 2004 session with the results of the effort.**

Tiered Copay for Self-Insured Plans



Tiered Copay for Self-Insured Plans

- Virginia State employees currently pay a $17 co-payment regardless of the actual cost of a drug.
- Many commercial payers, including the private managed care options available to State employees, employ tiered co-payments to induce employees to utilize lower-cost alternatives to high-cost therapies.

Tiered Copay for Self-Insured Plans

- **DHRM proposed co-payment structure could result in savings between $4.2 million and $5.7 million.**

Proposed DHRM Three-Tier Drug Plan

	Tier 1	Tier 2	Tier 3
Retail Pharmacy (34-day supply)	**$15**	**$20**	**$35**
Mail Order (90-day supply)	**$18**	**$33**	**$63**

Recommendation

- ***Recommendation (7).*** **The General Assembly may wish to direct the Department of Human Resource Management to implement the proposed tiered co-payment structure for the State's self-insured plans.**

Other Options for Savings

- **Two relatively new bulk purchasing options, used in other states, include interagency bulk purchasing and pooled purchasing across several states.**
  - **Georgia and Texas have implemented an interagency bulk purchasing program.**
  - **Vermont, Maine, and New Hampshire have recently developed a pooled purchasing arrangement across the three states.**
- **The Heinz Family Foundation, in conjunction with the actuarial firm William M. Mercer, is conducting a study of aggregate purchasing across a number of Virginia State agencies.**